

tion of effect was calculated to explain the potential mediating effect of leisure physical activity on the relationship between occupational social categories and CVD.

**Results** The incidence rates were respectively for: Hard CVD (2.4%), myocardial infarction (2.2%), angina (3.4%), coronary death (0.4%), total heart events (5.7%) and stroke (1.1%). Employees and manual workers have significant higher risks of hard cardiovascular events, myocardial infarction and total heart events compared with white collar, in crude analysis (HR=1.5). Adjustments for classical cardiovascular factors reduced significantly these risks while a weak impact of leisure physical activity on the relationships between occupational categories and each event was highlighted.

**Conclusion** The cardiovascular gradient observed between the different occupational categories is mainly explained by classical cardiovascular factors. Leisure physical activity is not sufficient by itself to compensate the occupational social inequalities.

*The author hereby declares no conflict of interest*

## 0235

### Incidence of sudden cardiac death in sub-Saharan Africa: the Douala-SCD registry

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**Background** A population-based incidence estimates of Sudden Cardiac Death (SCD) in sub-Saharan Africa (SSA) is unknown. We sought to determine the epidemiology of SCD in Douala, Cameroon.

**Method and results** During 12 months, 4 districts were randomly chosen to monitor all deaths. The COSA ("comité de santé") of each area registered every death, and a postgraduate fellow recorded detailed demographic and medical data for victims of natural death. A senior physician studied every case of suspected sudden death, either cardiac or extra-cardiac. For optimal exhaustiveness, surrounding hospital mortuaries were checked simultaneously to match identities of victims. Established SCD was defined as rapid witnessed collapses leading to death within 1h after the onset of symptoms, and probable SCD as unexpected death within 24h without obvious extra-cardiac cause. Our registry numbered 240 000 people and 2304 deaths. The overall mortality rate was 11.2/1000 inhabitants/year. Four (0.3%) were sudden extra-cardiac death, and 58 (2.5%) SCD of which 41.4% were established and 48.3% had <40 year-old. The incidence rate of SCD was 24.2/100 000 person-year. Coronary artery disease or dilated cardiomyopathy was able to be diagnosed in 13.8% cases. Out-of-hospital cardiac arrest (OHCA) occurred in 58.6% victims, of which 35.3% at home, and 58.8% in a cab, on the way towards hospital. Witness cardiac arrest was reported in 86.2% cases, but only 7.4% of victims experienced cardiopulmonary resuscitation attempts.

**Conclusion** Although not negligible, the SCD incidence in this SSA population is lower than that reported in most of western countries. However, as the vast majority of cases are witnessed cardiac arrests, the absence of CPR attempts raises the question of educating populations in providing basic life support rescue to tackle this potential reversible fatal outcome.

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## 0214

### Classifying heart failure patients to describe outpatient and inpatient care pathways in the French region Languedoc-Roussillon. First results of the cohort named "CarPathes"

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**Introduction** Care pathways are quickly developing involving hospital and out-of hospital cares for patients with heart failure (HF). To improve the clinical management and optimize the insurance economics, we aimed at describing the care pathways and the consistency with clinical status and care access.

**Methods** A retrospective cohort of patients living in the French region Languedoc-Roussillon was built. Inclusion criteria were mainly: first admission for HF in 2012; follow-up more than 1 year. The database we used (the SNIIRAM) include outpatient care claim data and hospitalization data. Patients were classified by a hierarchical ascending classification on principal components, using variables describing clinical status, use of specialized and non-specialized care, and main clinical outcomes (hospitalization, death).

**Results** 2751 patients were included and followed during a median of 22 months. Mean age was 78, 484 (18%) died, 818 (30%) were readmitted at least once for heart failure. The cluster analysis revealed three different significant groups: 1/ group 1 (N=734) is characterized by a younger age, more cares with cardiologists and less main clinical outcomes. Groups 2 and 3 are not different as regards age and comorbidities. 2/group 2 (N=1060) differs from the group 3 (N=957): less cares out-of the hospital contrasting with more cares at hospital, especially at emergencies.

**Conclusion** This cohort enables to evaluate consistency and adequation between cares and clinical status, following mail clinical outcomes. As this cohort is built in a heterogeneous region in terms of medical density or health organization, it should be a powerful tool for the study of spatial determinants.

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## 0490

### Prasugrel use in "real life": report from outpatient settings in France

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**Objective** of the study is to provide descriptive statistics on patterns of prasugrel usage in outpatient settings in France. The aim was to observe if the guidance for the use of Prasugrel from the European label was respected.

**Methods** This retrospective study was conducted to describe treatment patterns of prasugrel in outpatient settings in France using the IMS Disease Analyzer database, which collects electronic medical records of patients followed by a national representative of 1200 French general practitioners (GPs). Anonymous data are collected prospectively and continuously during each follow-up visit. The study population consisted of patients who had at least 1 prescription of prasugrel in outpatient settings starting from launch to 3 years post launch. The patients were followed from the date of the first prasugrel prescription recorded in the data base (index date) until they died, changed of GP or reached the end of the study, whichever came first.

**Results** In France, the IMS Disease Analyzer included 1.052 patients receiving at least one prescription of prasugrel from January 2010 until October 2012. 85% (n=894) were male (n=894), the mean age was 58.5 years. 5.7% of patients were aged more than 75 years, and 5.0% weighed 60kg or less. Only 0.2% (n=2) had a history of TIA/stroke among this cohort.

Prasugrel was prescribed at a daily maintenance dose of 10mg for 99.8% of patients (1.050 patients). Concomitant medications were usual (aspirin, lipid lowering agents, beta blockers, angiotensin-converting-enzyme (ACE)-inhibitors. 55.1% of patients received an anti-ulcer medication (mainly Proton Pump Inhibitor [PPI]). The persistence with prasugrel using the MPR (Medication Possession Ratio) was respectively 60.7% and 63.2% for patients with at 6 months (n=504) and 12 months follow-up (n=213). 13.7% of patients were switched from another thienopyridine (primarily clopidogrel).

**Conclusion** In prasugrel-treated patients, respect of Prasugrel indications was highly fulfilled. Almost all patients received aspirin combined to prasugrel. Of note, half of patients were treated with an anti-ulcer medication. The main results reflect a good usage of prasugrel by French GPs, in collaboration with cardiologists, with a satisfying understanding and implementation of the European label, in contrast with recent American registry's findings.

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